Arkansas Department of Health

Social Work Licensing Board

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Governor Asa Hutchinson
José Romero, MD, Secretary of Health
Ruthie Bain, Director

LCSW Supervision Evaluation

Supervisee: _____ **License #:** _____

Supervisor: _____ **License #:** _____

Dates of Supervision: From: _____ To _____ **# of Months:** _____
Month/Day/Year (same as on your Plan) Month/Day/Year

Average hours spent in weekly supervision: **Individual** _____ **Group** _____

Total Individual Hours: _____ **Total Group Hours:**_____ **Overall Direct Supervision Hours:**_____

Total number of hours worked in a social work position during this time period: _____

Evaluate the applicant/supervisee on the following:	Unable to Evaluate	Poor	Average	Above Average	Superior
Practice Skills					
1. Ability to assess/understand/access systems					
2. Individual/Family/Group Therapy					
3. Ability to identify and apply most applicable clinical model(s)					
4. Appropriate referral making skills					
5. Ability and willingness to self-assess					
6. Understand system development and policy implications					
7. Planned action implementation					
Skills Required for Continuing Competence					
1. Recognition of own limitations					
2. Understanding of intra/inter dependence of systems of care					
3. Capacity for professional and personal growth and development					
Development of Professional Identity					
1. Colleagues/peers perception of clinician's skills					
2. Ability to establish and maintain good professional relations					
3. Ability to identify, organize and manage agency goals and objectives					
Ethical Practice					
1. Understanding of & adherence to approved standards of professional/ethical conduct					
2. Personal Character: honesty, integrity, respect, service, general conduct, etc					
3. Sense of responsibility to client, community, agency and profession					

Please provide any additional information regarding the evaluation above that you may consider relevant.

_____

_____

I certify that the information above is true and correct to the best of my knowledge. I fully understand that all statements made on this form are subject to verification and that any false and misleading answer may be grounds for refusal or subsequent revocation or suspension of my license.

Signature of Supervisor: _____ **Date:** _____
This evaluation has been discussed with me, and I have received a copy of it.

Signature of Supervisee: _____ **Date:** _____
The supervisee must email, mail or fax this form to the Social Work Licensing Board **within 60 days from the last date of supervision**. This is the LMSW's responsibility.